MDR Tracking Number: M5-04-4014-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-23-04.

The IRO reviewed office visits, ROM testing, therapeutic procedures-group, massage, muscle testing, unlisted therapeutic procedure, chiropractic manipulative treatment and therapeutic exercises rendered from 07-29-03 through 11-20-03 that were denied based upon "U".

The IRO concluded that the therapeutic exercises and therapeutic procedures reviewed **were** medically necessary. The IRO concluded that the office visits, range of motion testing, massage, muscle testing, unlisted therapeutic procedures and chiropractic manipulative treatment **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-16-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 98940 dates of service 09-30-03 through 10-31-03 (5 DOS) denied with denial code "F" (Fee Guideline reduction). Per the Medicare program reimbursement methodologies per Rule 134.202(c) reimbursement is

recommended in the amount of $150.70 ($24.11 X 125% = $30.14 X 5 DOS). However, the requestor billed $30.13 for each date of service therefore reimbursement in the amount of $150.65 is recommended.

CPT code 97139-EU dates of service 09-30-03 through 10-15-03 (11 DOS) denied with denial code “F” (Fee Guideline reduction). Per the Medicare program reimbursement methodologies per Rule 134.202(c) reimbursement is recommended in the amount of $200.86 (14.61 X 125% = $18.28 X 11 DOS). However, the requestor billed $18.25 for each date of service therefore reimbursement in the amount of $200.75 is recommended.

CPT code 97124 dates of service 10-01-03 through 10-31-03 (9 DOS) denied with denial code “F” (Fee Guideline reduction). Per the Medicare program reimbursement methodologies per Rule 134.202(c) reimbursement is recommended in the amount of $231.30 ($20.56 X 125% = $25.70 X 9 DOS). However, the requestor billed $25.69 for each date of service therefore reimbursement in the amount of $231.21 is recommended.

CPt code 95851 date of service 10-14-03 denied with denial code “F” (Fee Guideline reduction). Per the Medicare program reimbursement methodologies per Rule 134.202(c) reimbursement is recommended in the amount of $30.61 ($24.49 X 125%). However, the requestor billed $30.60 and this is the amount recommended for reimbursement.

CPT code 97110 dates of service 10-15-03, 10-31-03 and 11-03-03 denied with denial code “F” (Fee Guideline reduction). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

CPT code 99213 date of service 11-05-03 denied with denial code “F” (Fee Guideline reduction).
Per the Medicare program reimbursement methodologies per Rule 134.202(c) reimbursement is recommended in the amount of $59.00 ($47.20 X 125%). However, the requestor billed for $58.99 therefore this is the recommended reimbursement.

CPT code 97750-MT (8 units) date of service 11-05-03 denied with denial code "F" (Fee Guideline reduction). Per the Medicare program reimbursement methodologies per Rule 134.202(c) reimbursement is recommended in the amount of $267.28 ($26.73 X 125% = $33.41 X 8 units). However, the requestor billed for $267.20. Additional reimbursement is recommended in the amount of $53.36 ($267.20 minus carrier payment of $213.84).

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies per Commission Rule 134.202(c) effective August 1, 2003 plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 08-01-03 through 11-12-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 29th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

October 18, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected disputed services.

Re: Medical Dispute Resolution
MDR #: M5-04-4014-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- letter of medical necessity - 08/19/04
- research, publications, etc. as basis of medical opinions
- medical narrative reports -11/05, 10/14, 10/09, 08/15, 07/29, 07/15, 07/08/03
- therapy progress notes - 07/08–11/20/03
- therapeutic procedures - 7/16-11/19/03
- ROM assessment – 11/05, 10/14, 08/15, 07/29/03
- nerve conduction velocity – 08/13/03
- operative report – disckectomy 09/10/03

Information provided by Respondent:
- correspondence - 08/11/04
- DD exam report - 01/06/04

Information provided by Neurosurgeon:
- Correspondence to treating doctor - 11/20, 10/20, 09/22, 08/19, 07/03/03.

Clinical History:
The claimant complained of low back pain following a work-related accident on ___. The MRI that showed a disc herniation on the left at L5-S1, but more prominently a left-sided herniation with evidence of extrusion at L4-L5. Given the impression or the information provided by the MRI, the injury in this patient is rather significant; however, through conservative treatment, this patient showed no progression.

Disputed Services:
Office visits, ROM testing, therapeutic procedures-group, massage, muscle testing, unlisted therapeutic procedure, chiropractic manipulative treatment and therapeutic exercises during the period of 07/29/03 through 11/20/03.

Decision:
The reviewer partially disagrees with the determination of the insurance carrier as follows:

Medically Necessary during the period in dispute:
- therapeutic exercises
- therapeutic procedures

Not Medically Necessary during the period in dispute:
- office visits
- range of motion testing
- massage
- muscle testing
- unlisted therapeutic procedures
- chiropractic manipulative treatment

Rationale:
Conservative treatment is the first priority. However, since the pain levels did not dramatically decrease, and therefore, a lack of progression was evident, the patient opted to proceed with surgery.

At that point in time, any range of motion therapeutic procedures, muscle testing, and chiropractic treatment should have been suspended per clearance from the surgeon to proceed. At that point in time, a Physical Activeness Readiness questionnaire should have been performed before any therapeutic exercises, whether phase I or phase II, were to be implemented. Pain free isometric exercises should have been in the treatment plan at that point in time to progress to an active rehab. During the course of that active rehab, a physical performance evaluation would document any progression. Therefore, muscle testing, range of motion, and therapeutic procedures would all be dependent upon those evaluations.

The partial agreement with the insurance carrier would therefore show any unlisted therapeutic procedures would not be recommended. If any muscle testing or range of motion, that would be included in your physical performance evaluation. Chiropractic manipulative treatment would not be recommended due to the laminectomy that was performed. Any type of manipulation to that area could further increase the pain levels, which were evident on the daily notes. The office visits, in my opinion, were excessive. I feel that the patient did not show progression as were stated by most peer-reviewed literature and literature on active rehab.

Denial, therefore, should be inclusive to the range of motion and muscle testing because that would be allowed on the physical performance evaluation. The unlisted therapeutic procedures, therefore, should be denied, and any chiropractic manipulative treatment after the day of surgery should also be denied. Therapeutic exercises after any pain-free isometric testing should be done. Also to be denied would be massage treatment

Sincerely,